STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burcham Hills Retirement Ctr	2700 Burcham Drive East Lansing, MI 48823

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45038

Based on observation, interview, and record review the facility failed to report allegations of abuse/neglect for one Resident (#3) of one resident sampled for abuse reporting of abuse/neglect.

Findings Included:

Resident #3(R3)

Review of the medical record revealed R3 was admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), type 2 diabetes, lung cancer, unstageable sacral pressure ulcer, fibromyalgia (widespread and long term body pain), epilepsy, anemia (low red blood cells), gastro-esophageal reflux disease, hypomagnesemia (low magnesium levels in blood), hyperlipidemia (high fat content in blood), sleep apnea, right foot drop, bipolar disorder, anxiety, nicotine dependence, and history of falls. R3's medical record demonstrated she was discharged from the facility on 07/29/2024 and was readmitted [DATE] that included new diagnoses of a closed fracture of upper end of the right tibia and a fracture of the upper end and lower end of right fibula. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2024, revealed a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15.

During an interview on 08/07/2024 at 11:29 a.m. R3 was observed sitting up in first floor conference room. R3 explained that she had come to the facility so that she could get stronger and return home. She explained that she was in a lot of pain because of a fall which had resulted in a fracture of her right leg. R3 explained that the fall happened at the facility. R3 explained that she was being transferred from the toilet in her bathroom, with the assistance of one person, her leg gave out and she fell to the floor. R3 explained that the recent fracture of her right leg has set her back in her progress to return home. R3 also explained that it was now necessary for her to be transferred using a total mechanical lift.

Review of R3's medical record demonstrated a plan of care which stated, Risk for falls r/t (related to) deconditioning, which was implemented as of 05/18/2024. R3's plan of care also stated, (Resident name) has ADL (Activity of Daily Living) deficits r/t recent hospitalization for pressure ulcer unstageable to sacrum, deconditioning, which was implemented 05/18/24. The same plan of care demonstrated an intervention that stated, Transfer: 2-person max assist, which was implemented 05/18/24 and was revised on 08/06/2024 to state Transfer: Hoyer (mechanical lift), NWB (Non-wt. bearing) on right lower extremity.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Burcham Hills Retirement Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Burcham Drive East Lansing, MI 48823	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility incident report demonstrated R3 had sustained a fall on 07/29/2024 at 09:00 p.m. Review of that incident report demonstrated Resident transferring from toilet to wheelchair, right leg gave out, patient fell to ground. Resident in pain ++, unable to move patient at time. Description of the incident demonstrated Physical/pain assessment, vitals, sheet placed under resident/pillow against right leg for support in non-movement, physician notified telephone message left,. Resident son notified, ambulance called. Resident transferred to (name of hospital) ED (emergency department) on stretcher, via (by) ambulance. Review of R3's hospital discharge summary, dated 8/25/24, revealed R3 had presented to the emergency department for a fall from standing with a closed right tibial fracture, a closed fracture of proximal end of right fibula, and closed fracture of proximal end of right tibia. The same discharge summary revealed R3 had required open reduction internal fixation right tibia on 08/02/2024. During an interview on 08/07/2024 at 11:35 a.m. Nurse Manger (NM) I explained that she was aware of R3's fall that had occurred on 07/29/2024. NM I explained that she had investigated R3's fall. NM I explained that her investigation demonstrated that R3 was being transferred from the toilet to her wheelchair by Certified Nurse Aide (CNA) D. NM I explained that according to R3's plan of care, she was to be transferred with the assistance of 2 staff. NM I explained that CNA D did not follow the plan of care. NM I agreed that by not following the plan of care, R3 had sustained a right closed fracture of upper end of the right tibia and a fracture of the upper end and lower end of right fibula. NM I explained that staff is expected to read the plan of care and the Kardex before providing care. NM I explained that that expectation was not followed by CNA D During a telephone interview on 08/08/2024 at 09:34 a.m. Certified Nurse Aide (CNA) D explained that she had worked at the facility for a month. CNA D explained that she was working with R3 on 07/29/2024 and was assisting her to transfer from the toilet to her wheelchair when R3's right leg gave out and R3 fell to the floor CNA D explained that she was not aware that R3 required to be transferred by 2 person max assistance . CNA D explained that she does not usually read the Kardex of residents and only relies on what she is told about resident care from other CNA's. CNA D was asked if she was educated on the necessity of reading the Kardex of Residents prior to providing care. CNA D explained that she was not taught to read the Kardex prior to providing Resident care. Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CNA) D was hired by the facility 06/17/2024. The personnel record of CNA D had not demonstrated a completed competency evaluation upon completion of her orientation. During an interview on 08/07/2024 at 12:21 p.m. Nursing Home Administrator (NHA) A explained that she was aware of R3's fall, which has occurred on 07/29/2024. NHA A explained that she was made aware of the incident on the date that it occurred but was on vacation at that time. NHA A explained that she had asked the covering person to investigate the incident to see if the plan of care was followed. NHA A explained that she had just returned from vacation on 08/06/2024. NHA A' explained that she was made aware that the plan of care was not followed resulting in R3's fall on 08/06/2024. NHA A was asked if not following the plan of care, resulting in a fracture, could be defined as an allegation of neglect? NHA A responded yes, it could be an allegation of neglect. NHA A could not explain why it had not been investigated immediately or reported to the appropriate State Agency. NHA A explained that she would report the allegation of neglect immediately now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burcham Hills Retirement Ctr	2700 Burcham Drive East Lansing, MI 48823

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45038

Based on observation, interview, and record review the facility failed to investigate, implement preventive measures, and take correction action for an allegation of abuse/neglect for one resident (#3) of one resident review for abuse/neglect.

Findings Included:

Resident #3(R3)

Review of the medical record revealed R3 was admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), type 2 diabetes, lung cancer, unstageable sacral pressure ulcer, fibromyalgia (widespread and long term body pain), epilepsy, anemia (low red blood cells), gastro-esophageal reflux disease, hypomagnesemia (low magnesium levels in blood), hyperlipidemia (high fat content in blood), sleep apnea, right foot drop, bipolar disorder, anxiety, nicotine dependence, and history of falls. R3's medical record demonstrated she was discharged from the facility on 07/29/2024 and was readmitted [DATE] that included new diagnoses of a closed fracture of upper end of the right tibia and a fracture of the upper end and lower end of right fibula. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2024, revealed a Brief

Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15.

During an interview on 08/07/2024 at 11:29 a.m. R3 was observed sitting up in first floor conference room. R3 explained that she had come to the facility so that she could get stronger and return home. She explained that she was in a lot of pain because of a fall which had resulted in a fracture of her right leg. R3 explained that the fall happened at the facility. R3 explained that she was being transferred from the toilet in her bathroom, with the assistance of one person, her leg gave out and she fell to the floor. R3 explained that the recent fracture of her right leg has set her back in her progress to return home. R3 also explained that it was now necessary for her to be transferred using a total mechanical lift.

Review of R3's medical record demonstrated a plan of care which stated, Risk for falls r/t (related to) deconditioning, which was implemented as of 05/18/2024. R3's plan of care also stated, (Resident name) has ADL (Activity of Daily Living) deficits r/t recent hospitalization for pressure ulcer unstageable to sacrum, deconditioning, which was implemented 05/18/24. The same plan of care demonstrated an intervention that stated, Transfer: 2-person max assist, which was implemented 05/18/24 and was revised on 08/06/2024 to state Transfer: Hoyer (mechanical lift), NWB (Non-wt. bearing) on right lower extremity.

Review of facility incited report demonstrated R3 had sustained a fall on 07/29/2024 at 09:00 p.m. Review of that incident report demonstrated Resident transferring from toilet to wheelchair, right leg gave out, patient fell to ground. Resident in pain ++, unable to move patient at time. Description of the incident demonstrated Physical/pain assessment, vitals, sheet placed under resident/pillow against right leg for support in non-movement, physician notified telephone message left,. Resident son notified, ambulance called. Resident transferred to (name of hospital) ED (emergency department) on stretcher, via (by) ambulance.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burcham Hills Retirement Ctr	2700 Burcham Drive East Lansing, MI 48823

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's hospital discharge summary, dated 8/25/24, revealed R3 had presented to the emergency department for a fall from standing with a closed right tibial fracture, a closed fracture of proximal end of right fibula, and closed fracture of proximal end of right tibia. The same discharge summary revealed R3 had required open reduction internal fixation right tibia on 08/02/2024. During an interview on 08/07/2024 at 11:35 a.m. Nurse Manger (NM) I explained that she was aware of R3's fall that had occurred on 07/29/2024. NM I explained that she had investigated R3's fall. NM I explained that her investigation demonstrated that R3 was being transferred from the toilet to her wheelchair by Certified Nurse Aide (CNA) D. NM I explained that according to R3's plan of care, she was to be transferred with the assistance of 2 staff. NM I explained that CNA D did not follow the plan of care. NM I agreed that by not following the plan of care, R3 had sustained right a closed fracture of upper end of the right tibia and a fracture of the upper end and lower end of right fibula. NM I explained that staff is expected to read the plan of care and the Kardex before providing care. NM I explained that that expectation was not followed by CNA D. During a telephone interview on 08/08/2024 at 09:34 a.m. Certified Nurse Aide (CNA) D explained that she had worked at the facility for a month. CNA D explained that she was working with R3 on 07/29/2024 and was assisting her to transfer from the toilet to her wheelchair when R3's right leg gave out and R3 fell to the floor CNA D explained that she was not aware that R3 required to be transferred by 2 person max assistance . CNA D explained that she does not usually read the Kardex of residents and only relies on what she is told about resident care from other CNA's. CNA D was asked if she was educated on the necessity of reading the Kardex of Residents prior to providing care. CNA D explained that she was not taught to read the Kardex prior to providing Resident care. Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CNA) D was hired by the facility 06/17/2024. The personnel record of CNA D had not demonstrated a completed competency evaluation upon completion of her orientation. During an interview on 08/07/2024 at 12:21 p.m. Nursing Home Administrator (NHA) A explained that she was aware of R3's fall, which has occurred on 07/29/2024. NHA A explained that she was made aware of the incident on the date that it occurred but was on vacation at that time. NHA A explained that she had asked the covering person to investigate the incident to see if the plan of care was followed. NHA A explained that she had just returned from vacation on 08/06/2024. NHA A' explained that she was made aware that the plan of care was not followed resulting in R3's fall on 08/06/2024. NHA A was asked if not following the plan of care, resulting in a fracture, could be defined as an allegation of neglect? NHA A responded yes, it could be an allegation of neglect. NHA A was asked why it was not investigated immediately and report to the appropriate State of Michigan Agency? NHA A could not explain why it had not been investigated immediately or reported to the appropriate State Agency. NHA A explained that she would report the allegation of neglect immediately now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burcham Hills Retirement Ctr	2700 Burcham Drive East Lansing, MI 48823

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 This citation pertains to intake: MI00146060 Based on observation, interview, and record review the facility failed to prevent accidents (falls) by not following the plan of care, for two Resident (#2, #3) out of three Residents reviewed for accidents and hazards resulting in actual harm, fractured bones resulting in decline in Activities of Daily living for Resident #3 and potential for injury for Resident #2. Findings Included: Resident #3(R3) Review of the medical record revealed R3 was admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), type 2 diabetes, lung cancer, unstageable sacral pressure ulcer, fibromyalgia (widespread and long term body pain), epilepsy, anemia (low red blood cells), gastro-esophageal reflux disease, hypomagnesemia (low magnesium levels in blood), hyperlipidemia (high fat content in blood), sleep apnea, right foot drop, bipolar disorder, anxiety, nicotine dependence, and history of falls. R3's medical record demonstrated she was discharged from the facility on 07/29/2024 and was readmitted [DATE] that included new diagnoses of a closed fracture of upper end of the right tibia and a fracture of the upper end and lower end of right fibula. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2024, revealed a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During an interview on 08/07/2024 at 11:29 a.m. R3 was observed sitting up in first floor conference room. R3 explained that she had come to the facility so that she could get stronger and return home. She explained that she was in a lot of pain because of a fall which had resulted in a fracture of her right leg. R3 explained that the fall happened at the facility. R3 explained that she was being transferred from the toilet in her bathroom, with the assistance of one person, her leg gave out and she fell to the floor. R3 explained that the recent fracture of her right leg has set her back in her progress to return home. R3 also explained that it was now necessary for her to be transferred using a total mechanical lift. Review of R3's medical record demonstrated a plan of care which stated, Risk for falls r/t (related to) deconditioning, which was implemented as of 05/18/2024. R3's plan of care also stated, (Resident name) has ADL (Activity of Daily Living) deficits r/t recent hospitalization for pressure ulcer unstageable to sacrum, deconditioning, which was implemented 05/18/24. The same plan of care demonstrated an intervention that stated, Transfer: 2-person max assist, which was implemented 05/18/24 and was revised on 08/06/2024 to state Transfer: Hoyer (mechanical lift), NWB (Non-wt. bearing) on right lower extremity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burcham Hills Retirement Ctr	2700 Burcham Drive East Lansing, MI 48823

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Actual harm

Residents Affected - Few

Review of facility incited report demonstrated R3 had sustained a fall on 07/29/2024 at 09:00 p.m. Review of that incident report demonstrated Resident transferring from toilet to wheelchair, right leg gave out, patient fell to ground. Resident in pain ++, unable to move patient at time. Description of the incident demonstrated Physical/pain assessment, vitals, sheet placed under resident/pillow against right leg for support in non-movement, physician notified telephone message left,. Resident son notified, ambulance called. Resident transferred to (name of hospital) ED (emergency department) on stretcher, via (by) ambulance.

Review of R3's hospital discharge summary, dated 8/25/24, revealed R3 had presented to the emergency department for a fall from standing with a closed right tibial fracture, a closed fracture of proximal end of right fibula, and closed fracture of proximal end of right tibia. The same discharge summary revealed R3 had required open reduction internal fixation right tibia on 08/02/2024.

During an interview on 08/07/2024 at 11:35 a.m. Nurse Manger (NM) I explained that she was aware of R3's fall that had occurred on 07/29/2024. NM I explained that she had investigated R3's fall. NM I explained that her investigation demonstrated that R3 was being transferred from the toilet to her wheelchair by Certified Nurse Aide (CNA) D. NM I explained that according to R3's plan of care, she was to be transferred with the assistance of 2 staff. NM I explained that CNA D did not follow the plan of care. NM I agreed that by not following the plan of care, R3 had sustained right a closed fracture of upper end of the right tibia and a fracture of the upper end and lower end of right fibula. NM I explained that staff is expected to read the plan of care and the Kardex before providing care. NM I explained that that expectation was not followed by CNA D

During a telephone interview on 08/08/2024 at 09:34 a.m. Certified Nurse Aide (CNA) D explained that she had worked at the facility for a month. CNA D explained that she was working with R3 on 07/29/2024 and was assisting her to transfer from the toilet to her wheelchair when R3's right leg gave out and R3 fell to the floor CNA D explained that she was not aware that R3 required to be transferred by 2 person max assistance . CNA D explained that she does not usually read the Kardex of residents and only relies on what she is told about resident care from other CNA's. CNA D was asked if she was educated on the necessity of reading the Kardex of Residents prior to providing care. CNA D explained that she was not taught to read the Kardex prior to providing Resident care.

Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CNA) D was hired by the facility 06/17/2024. The personnel record of CNA D had not demonstrated a completed competency evaluation upon completion of her orientation.

Resident #2 (R2)

Review of the medical record revealed R2 was admitted [DATE] with diagnoses that included peripheral vascular disease (PVD), Alzheimer's disease, dementia, hypertensive kidney disease, stage 3 chronic kidney disease, hypothyroidism (low thyroid hormone), hyperlipidemia (high fat content in blood), polyneuropathy (damage or disease affecting peripheral nerves), second degree atrioventricular block (delayed cardiac conduction in cardiac node), venous insufficiency, osteoarthritis, low back pain, depression, absence of right leg below knee. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2024, revealed a Brief Interview for Mental Status (BIMS) of 12 (mildly impaired cognition) out of 15.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Burcham Hills Retirement Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Burcham Drive East Lansing, MI 48823	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/07/2024 at 01:55 p.m. R2 was observed setting up in a chair. R2 explained that he recently had a fall that had occurred in the bathroom. He explained that he needed assistance to get off the toilet and that a Certified Nursing Aide (CNA) was assisting him, and she was unable to hold him up and another CNA assisted him and lowered him to the floor. R2 explained that he was supposed to be transferred with an easy stand but that the staff did not use it at that time. R2 explained that it was a new CNA and she did not know that he was to be transferred with the easy stand. R2 explained that he did not sustain any injury. Review of R2's medical record demonstrated a physician order mechanical lift for transfers which was entered 08/08/2024. Review of R2's plan of care demonstrated . is at risk for falls r/t(relate to) spondylosis, R (right) BKA (below the knee amputation) polyneuropathy, Alzheimer's disease. R2's plan of care demonstrated an intervention EZ stand, which was entered 07/08/2024. Review of R2's Kardex (document used by staff that are providing care of the resident) demonstrated Transfer-Mobility- Transfer EZ stand. Review of facility incident report demonstrated R2 had experience a fall on 07/29/2024 at 04:30 p.m. The report demonstrated Resident was being toileted, unable to continue standing by self-using safety bars, fell to floor. The same incident report demonstrated that R2 did not sustain any injuries. Review a provided facility summary demonstrated Certified Nurse Aide (CNA) D was assisting R2 while he was standing up holding onto the assistance bar when he was non longer able to stand. The summary then identified that CNA E arrived in the bathroom and lowered R2 to the floor. During a telephone interview on 08/08/2024 at 09:34 a.m. Certified Nurse Aide (CNA) D explained that she had worked at the facility for a month. CNA D explained that she was assisting R2 in the bathroom on 07/29/24. During the transfer from the toilet R2 was unable to stand. CNA D explained that CNA E arrived in the bathroom and observed R2 being unable to stand and asked CNA D to remove the wheelchair while CNA E lowered R2 to the floor. CNA D explained that she was not aware that R2 required to be transferred with a mechanical device called a EZ-Stand. CNA D explained that she does not usually read the Kardex of residents and only relies on what she is told about resident care from other CNA's. CNA D was asked if she was educated on the necessity of reading the Kardex of Residents prior to providing care. CNA D explained that she was not taught to read the Kardex prior to providing Resident care. Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CNA) D was hired by the facility 06/17/2024. The personnel record of CNA D had not demonstrated a completed competency evaluation upon completion of her orientation. During a telephone interview on 08/08/2024 at 10:31 a.m. Certified Nurse Aide (CNA) E explained that she had worked at the facility for almost a year. CNA E explained that she was working with CNA D on 07/29/24. CNA E explained that she was aware that R2 was on the toilet when she first arrived for her shift. She explained that she was aware that R2's Kardex demonstrated that R2 needed a EZ-Stand for the use of transfers. CNA E explained that she had told CNA D to contact her when R2 was ready to be transferred from the toilet to the wheelchair. CNA E explained that it had been a prolonged amount of time and CNA D had not contacted her for the transfer yet, so she went to R2's bathroom. CNA E explained that when she entered the bathroom, she observed that R2 could not stand while being helped by CNA D so she asked her to move and CNA E assisted R2 to the floor. CNA E explained that an EZ-Stand was not in the bathroom and because R2 was observed falling she assisted him to the floor.

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Burcham Hills Retirement Ctr	2700 Burcham Drive East Lansing, MI 48823

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45038 This citation pertains to intake: MI00146060. Based on interview and record review the facility failed to ensure that five Certified Nurse Aides (CNA)(D, E, F,G, and H) had the required initial competency evaluation and techniques necessary to care for Residents. Findings Included: Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CAN) D was hired by the facility 06/17/2024. The personnel record of CNA D had not demonstrated a completed competency evaluation upon completion of her orientation. Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CNA) E was hired by the facility 08/24/2023. The personnel record of CNA E had not demonstrated a completed competency evaluation upon completion of her orientation. Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CNA) F was contracted CNA that started at the facility 12/28/2023. The personnel record of CNA F had not demonstrated a completed competency evaluation upon completion of her orientation to the facility. Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CNA) G was hired by the facility 05/30/2024. The personnel record of CNA G had not demonstrated a completed competency evaluation upon completion of his orientation. Record review of the facility staff personnel records demonstrated Certified Nurse Aide (CNA) H was hired by the facility 05/16/2024. The personnel record of CNA H had not demonstrated a completed competency evaluation upon completion of his orientation. During an interview on 08/24/2024 at 10:57 a.m. Human Resource Director O explained that she could not locate the completed competency evaluation forms for the above listed Certified Nursing Aides (CNA's). During an interview on 08:25;2024 at 12:25 p.m. Nurse Educator P explained that each employee was to have a completed competency evaluation once the orientation process was completed. She explained that the competency evaluations were to be completed by the Nurse Managers and once completed the staff would be allowed to work independently. Nurse Educator P explained that each Certified Nurse Aide (CNA), listed above, had been working independently. Nurse Educator P explained that she could not locate the five CNA's completed competency evaluations. Nurse Educator P could not explain why the completed competency evaluations had not been completed.